Technische Universität Berlin

Health care systems in Europe

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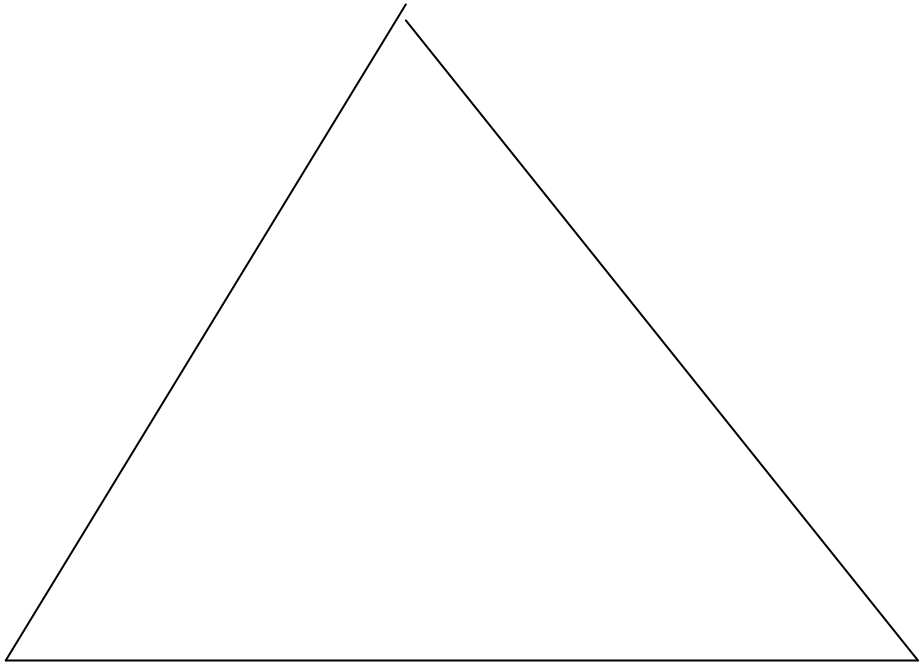
Third-party Payer



Population **Providers**

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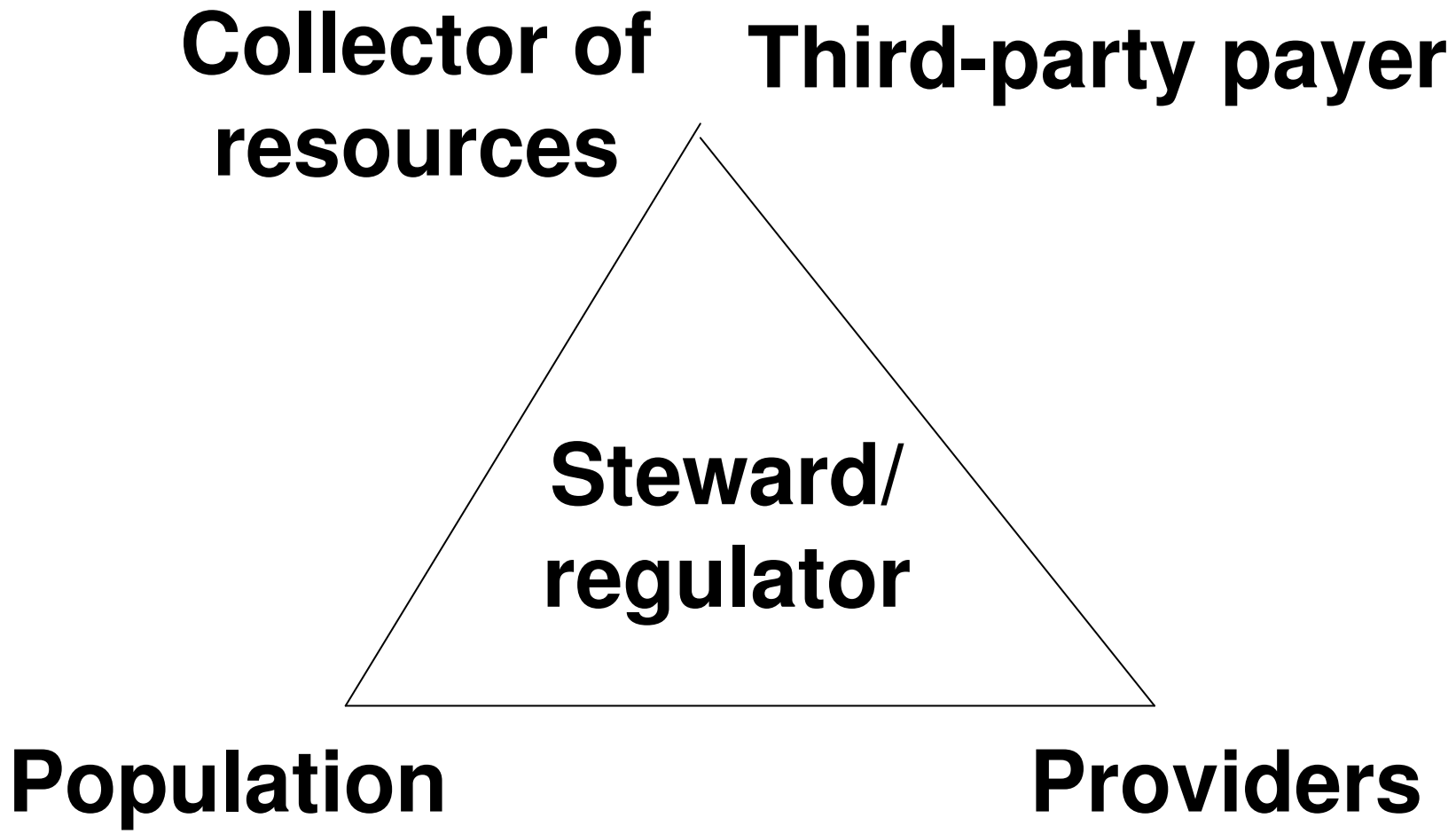

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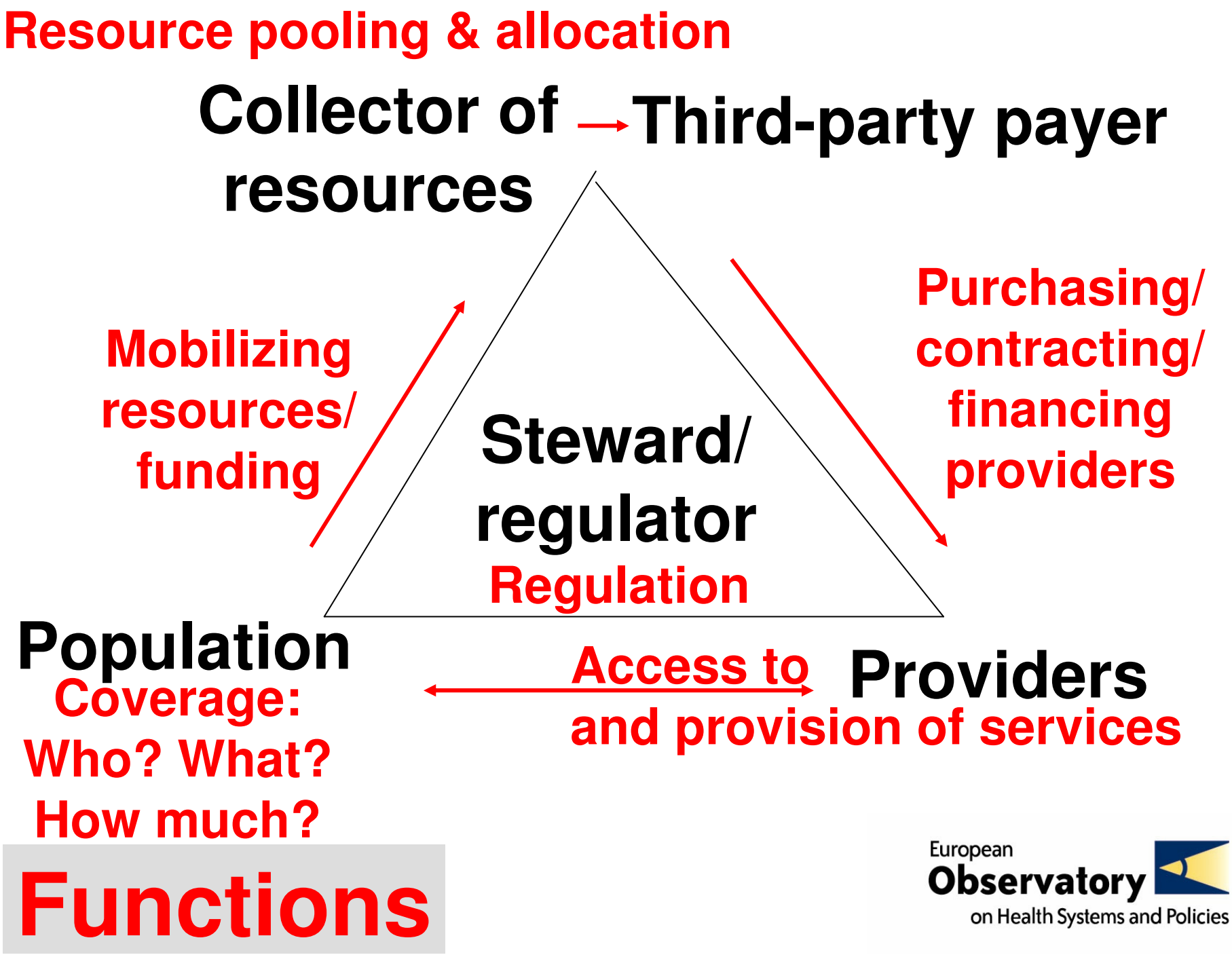
Resource pooling & allocation
Collector of resources
Third-party payer
Mobilizing resources/ funding
Purchasing/ contracting/ financing providers
Steward/ regulator
Regulation
Population
Coverage:
Who? What?
How much?
Access to
and provision of services
Providers
Functions
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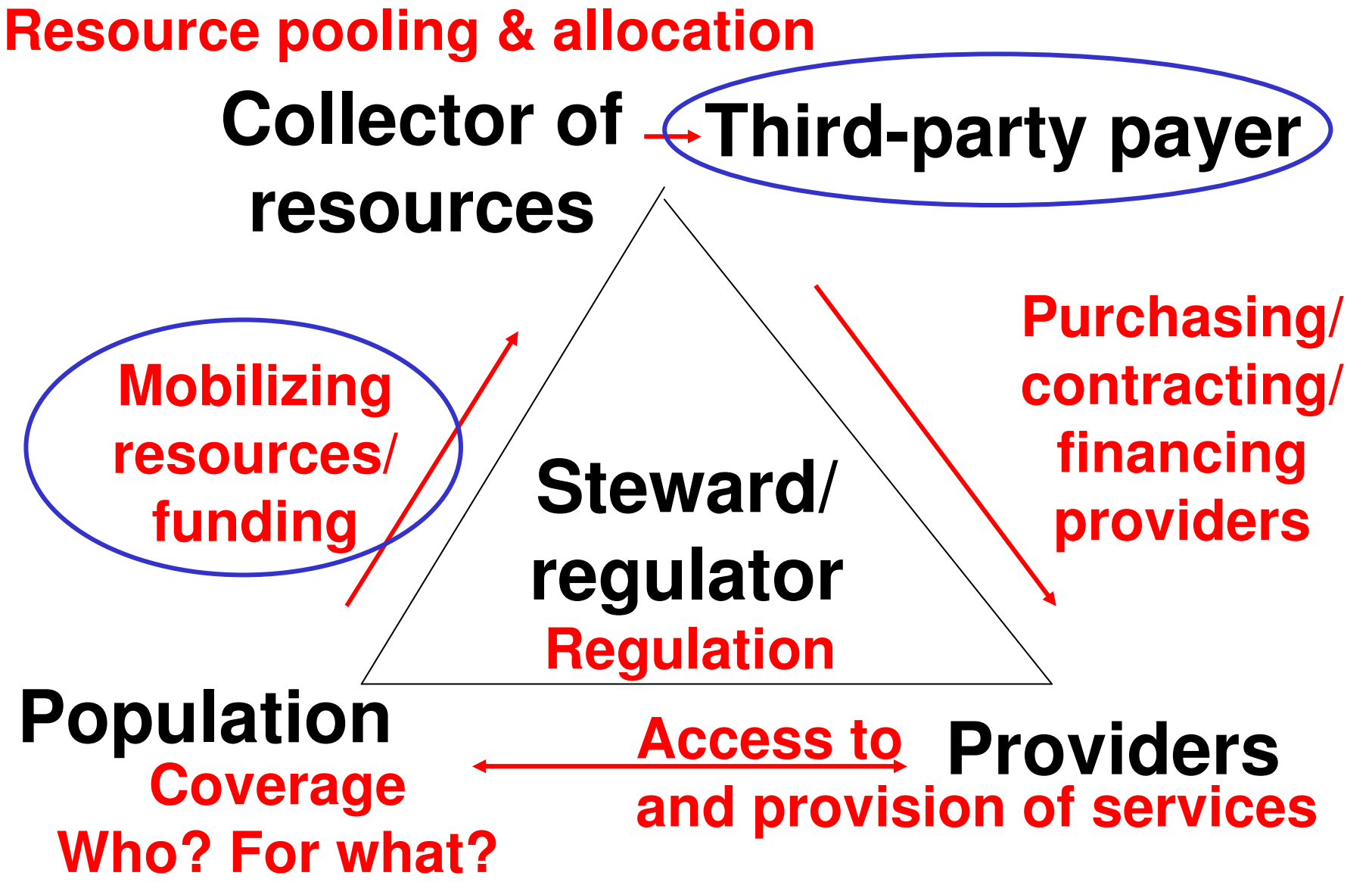

System typology

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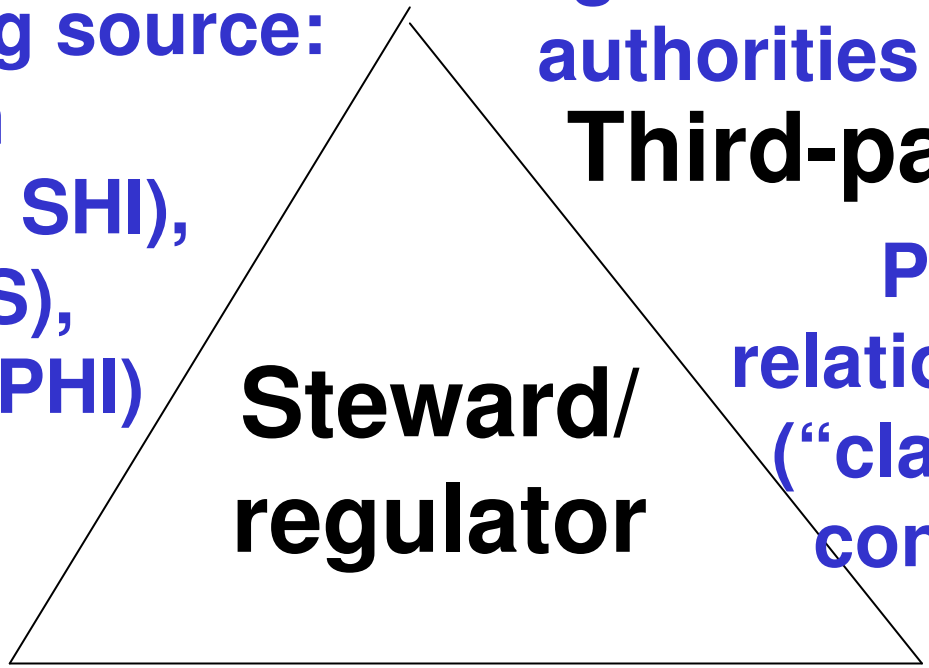
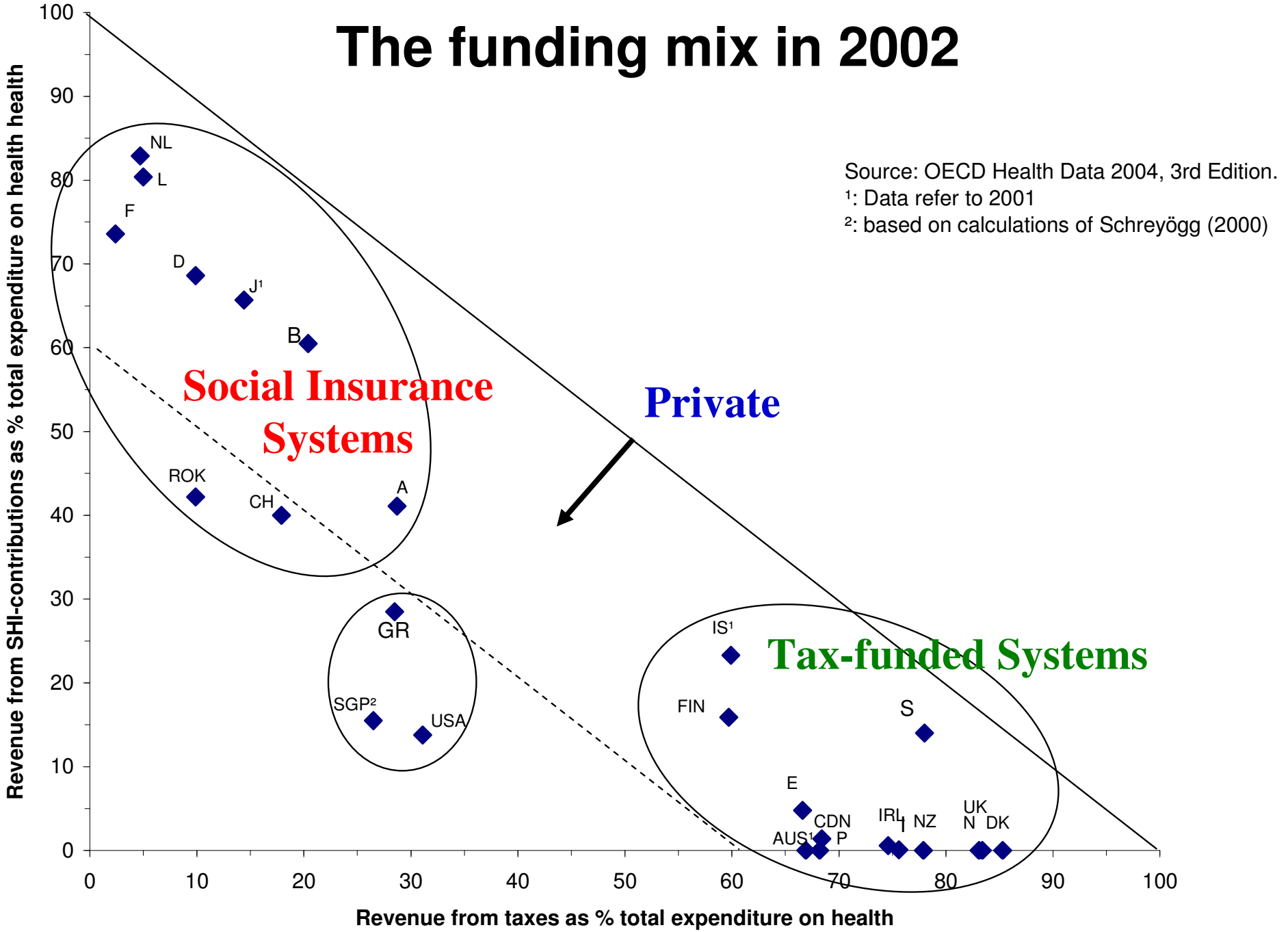
System typology

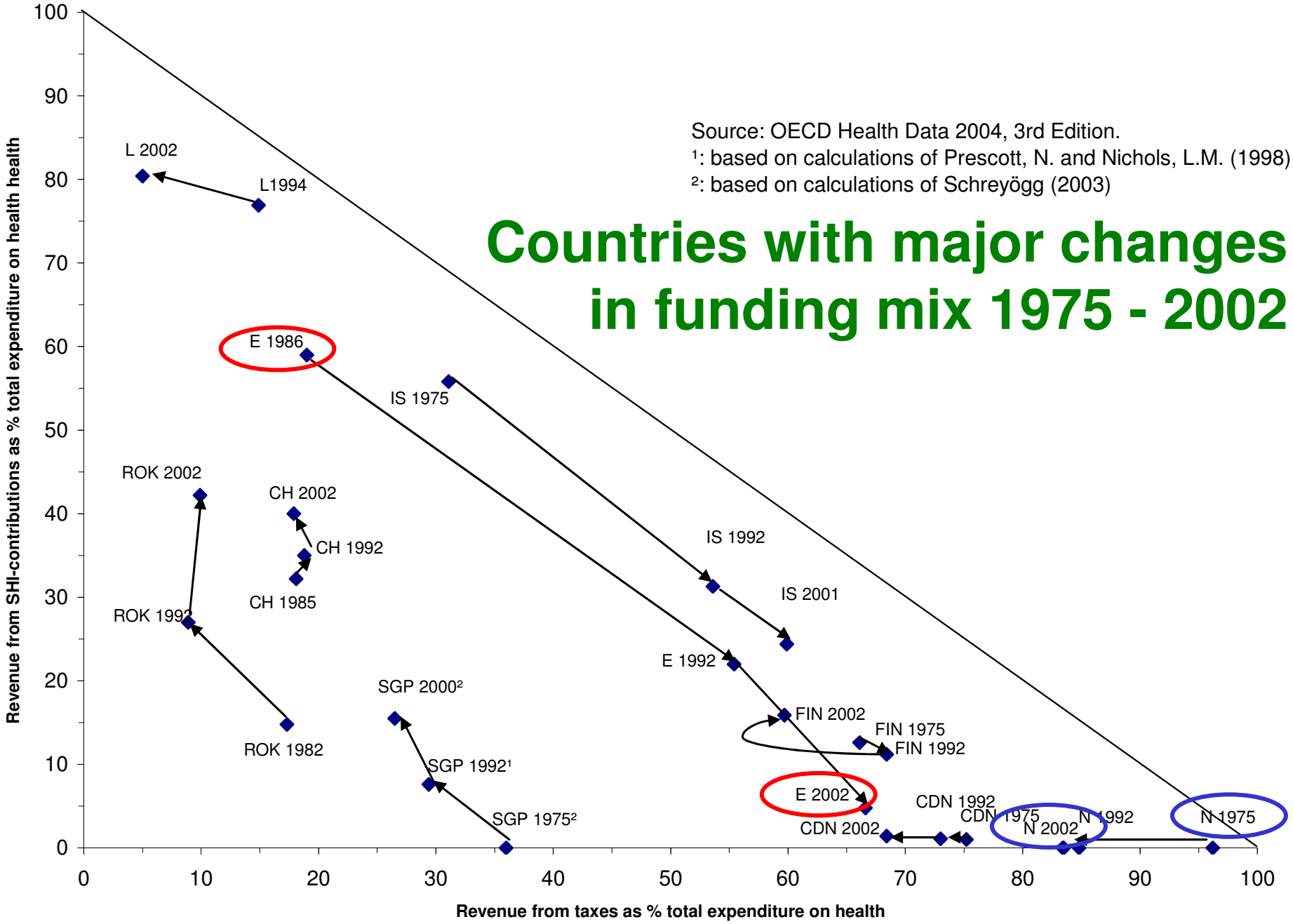


SHI = Social health insurance
NHS = National Health Service
PHI = Private health insurance

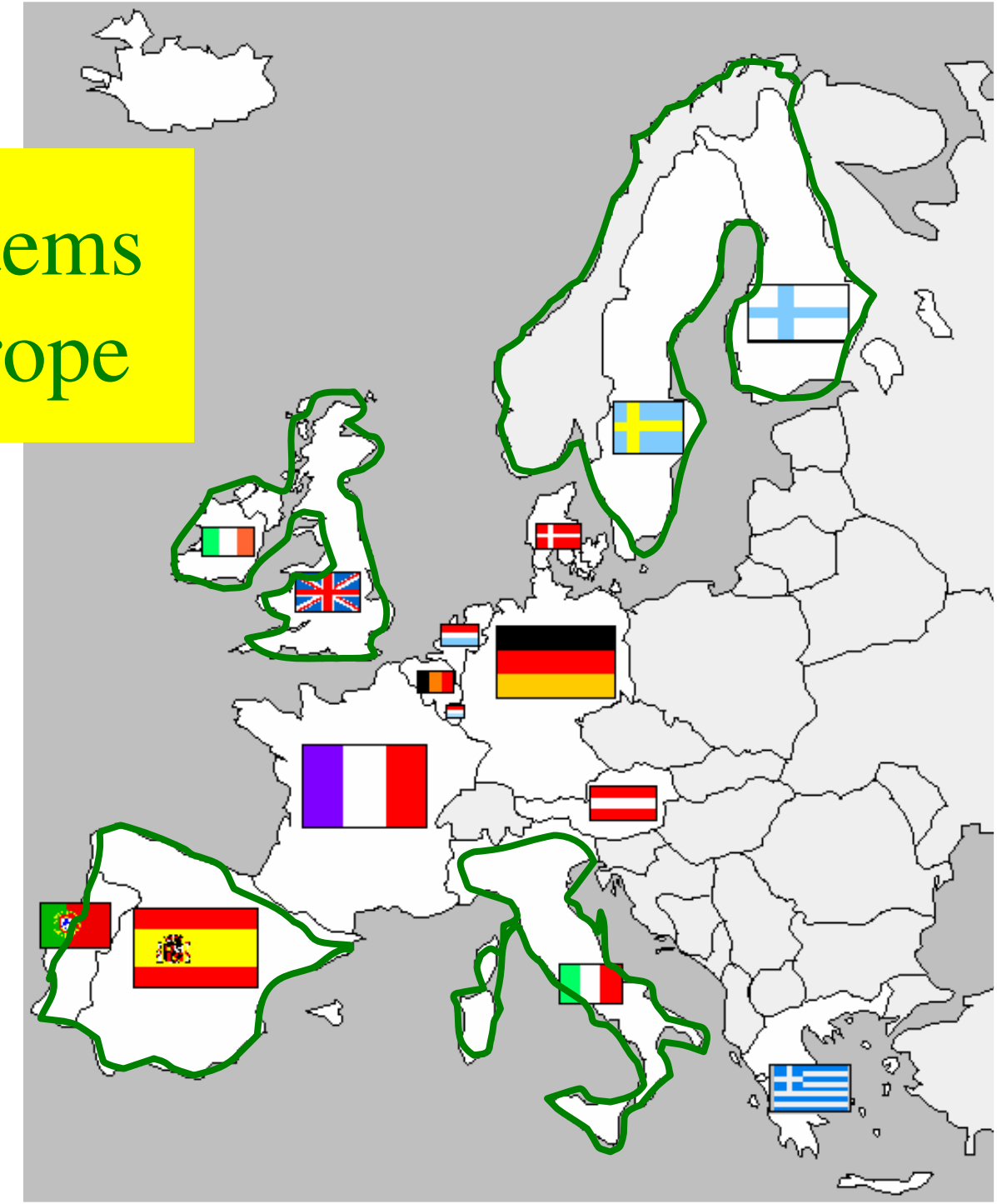
The funding mix in 2002



Source: OECD Health Data 2004, 3rd Edition.
[1]: Data refer to 2001
[2]: based on calculations of Schreyögg (2000)


Source: OECD Health Data 2004, 3rd Edition.
1: based on calculations of Prescott, N. and Nichols, L.M. (1998)
2: based on calculations of Schreyögg (2003)
Countries with major changes in funding mix 1975 - 2002
Revenue from SHI-contributions as % total expenditure on health health
Revenue from taxes as % total expenditure on health
0
10
20
30
40
50
60
70
80
90
100
L 2002
L1994
E 1986
IS 1975
IS 1992
IS 2001
ROK 2002
CH 2002
CH 1992
CH 1985
ROK 1992
ROK 1982
E 1992
SGP 2000²
SGP 1992¹
SGP 1975²
FIN 2002
FIN 1975
FIN 1992
E 2002
CDN 1992
CDN 1975
CDN 2002
N 2002
N 1992
N 1975

Tax-based systems in western Europe



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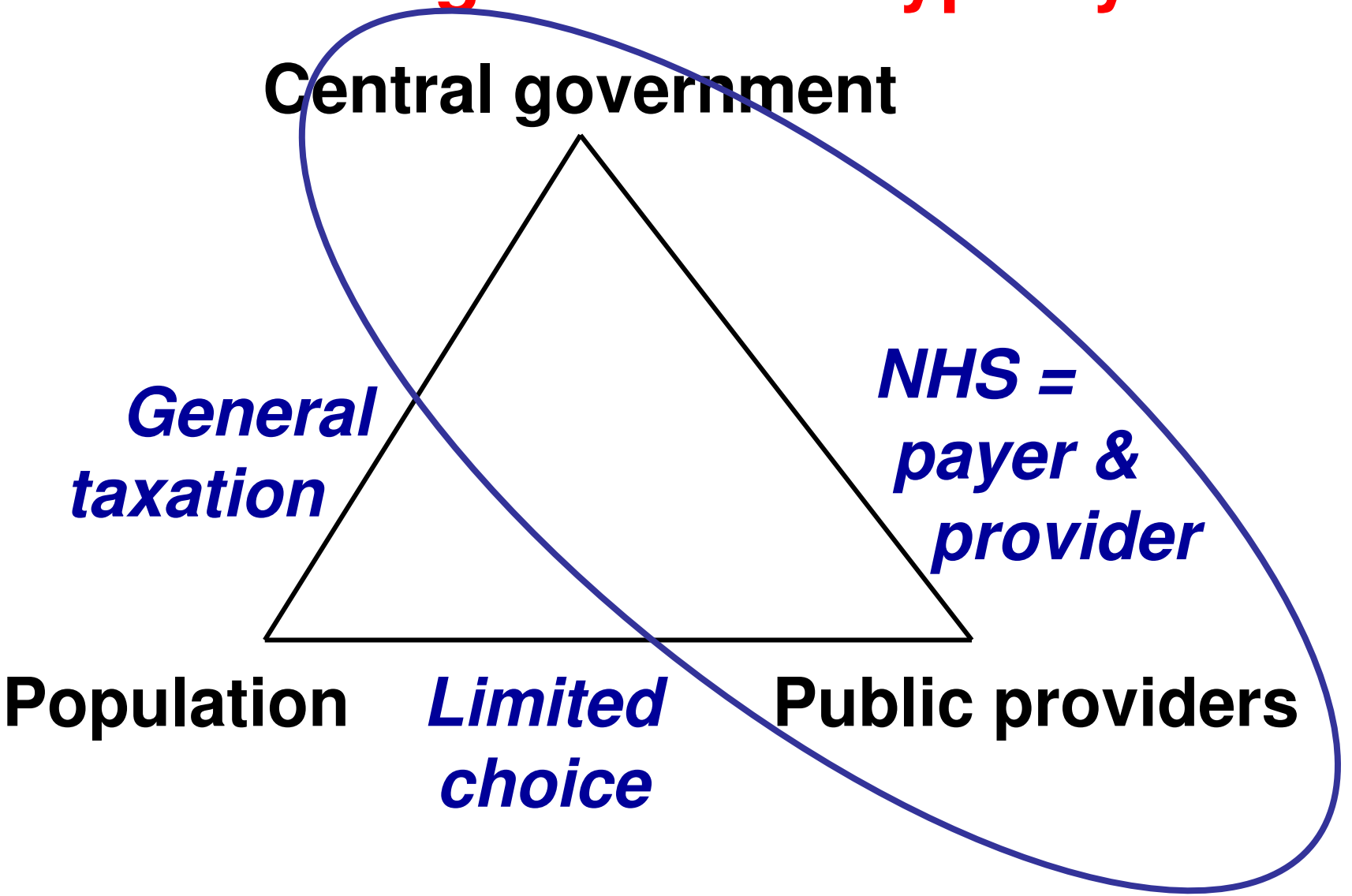
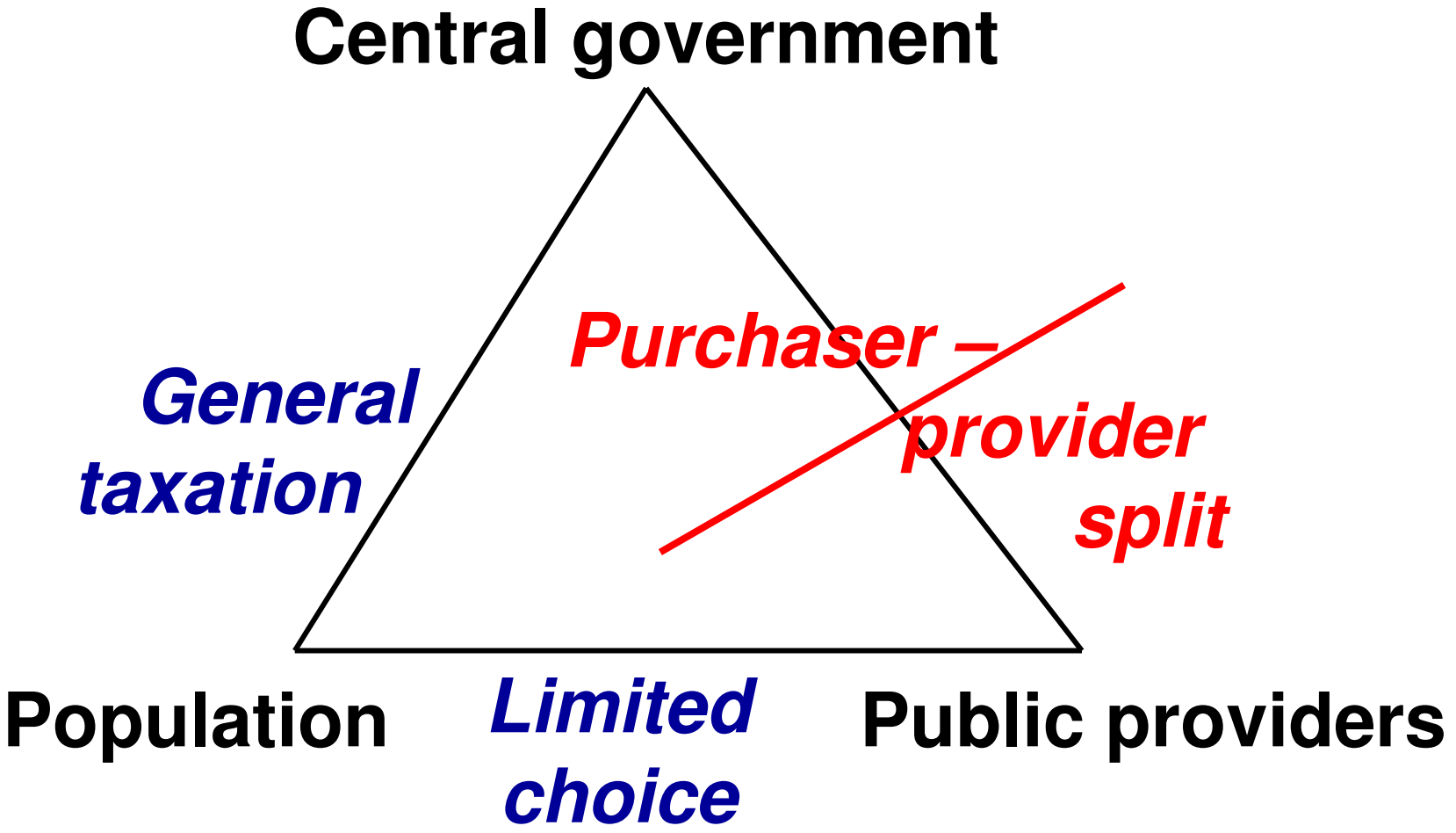
Classical integrated NHS-type system

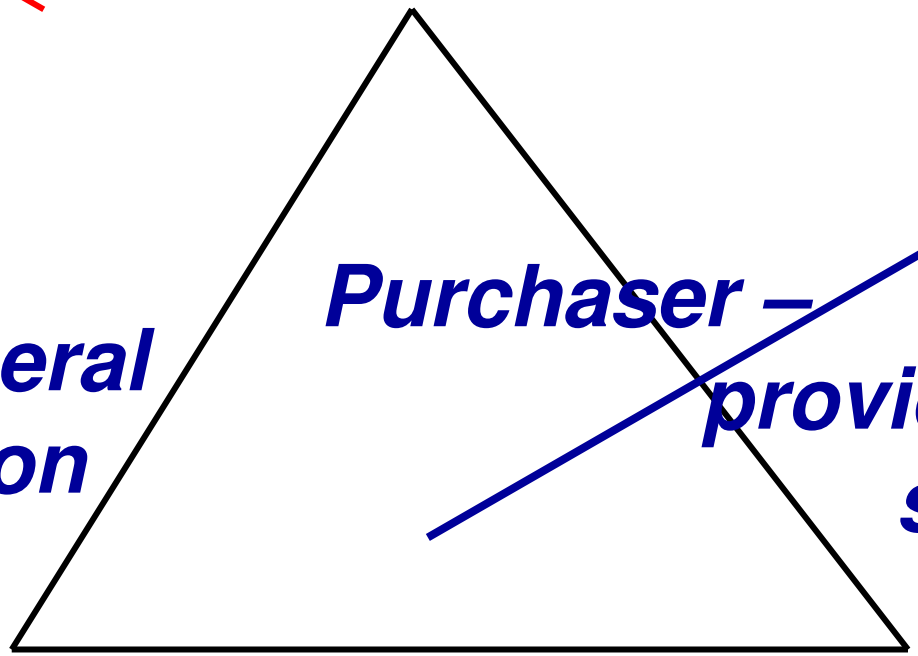


Development 1



Development 2

~~Central~~ Regional governments



General taxation

Purchaser – provider split

Population

Limited choice

Public providers

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Development 2

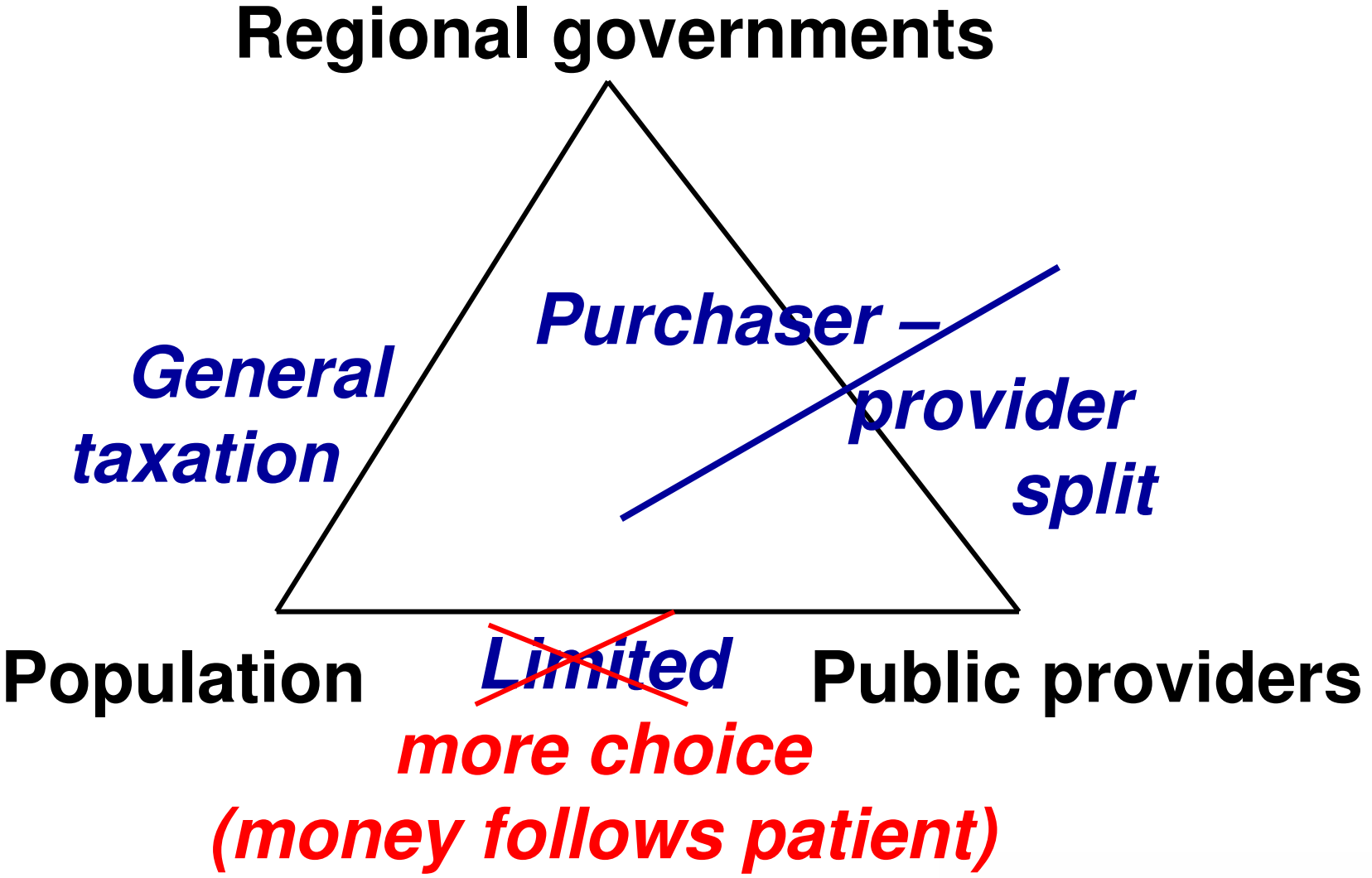
~~Central~~ Regional governments

Questions arising:

- **Funding from national or regional taxation?**
- **Benefit catalogue uniform?**
- **Supply density and quality regulated uniformly?**
- **Access to services across regional borders?**

Population — ***Limited choice*** — **Public providers**

Development 3



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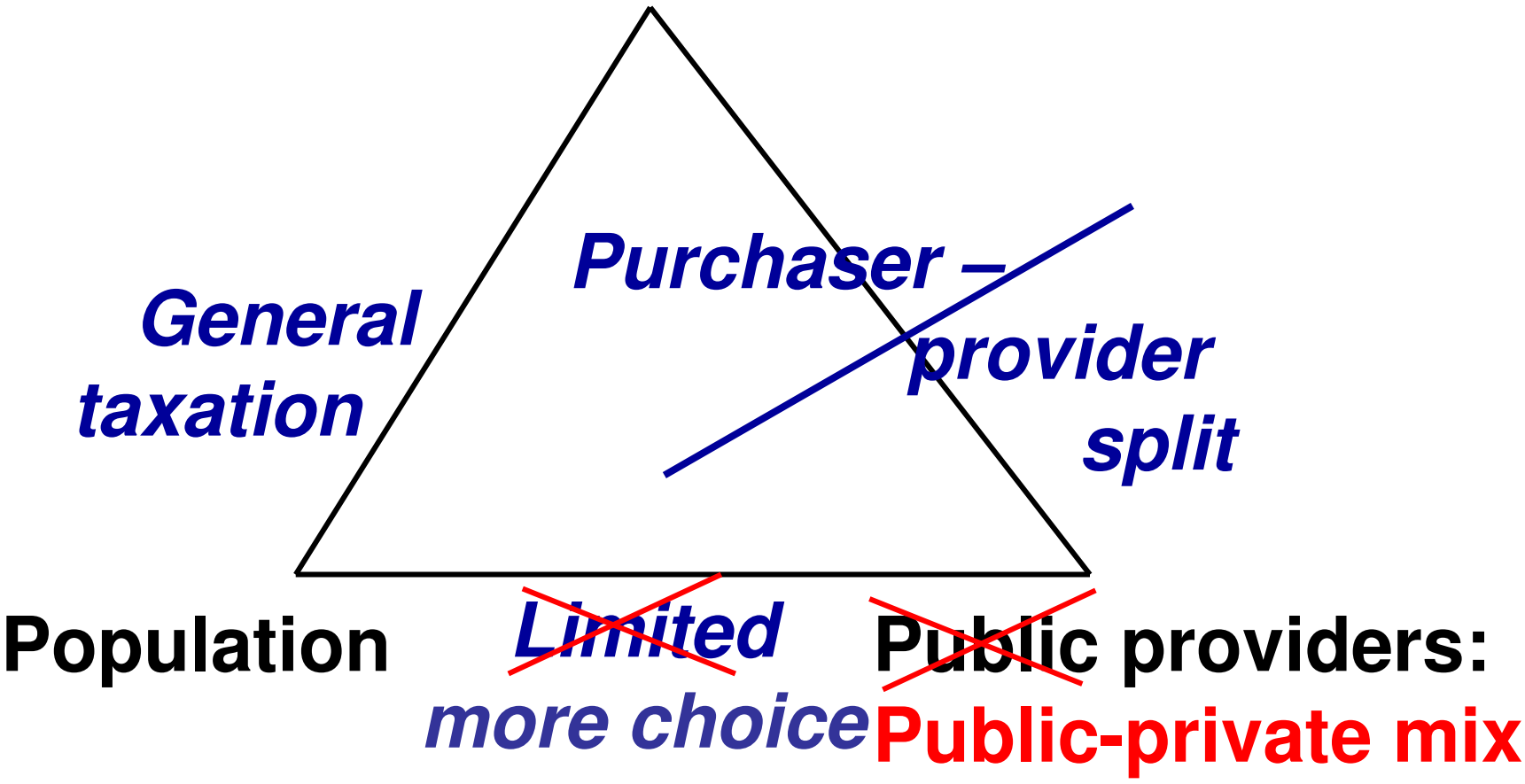
Development 4



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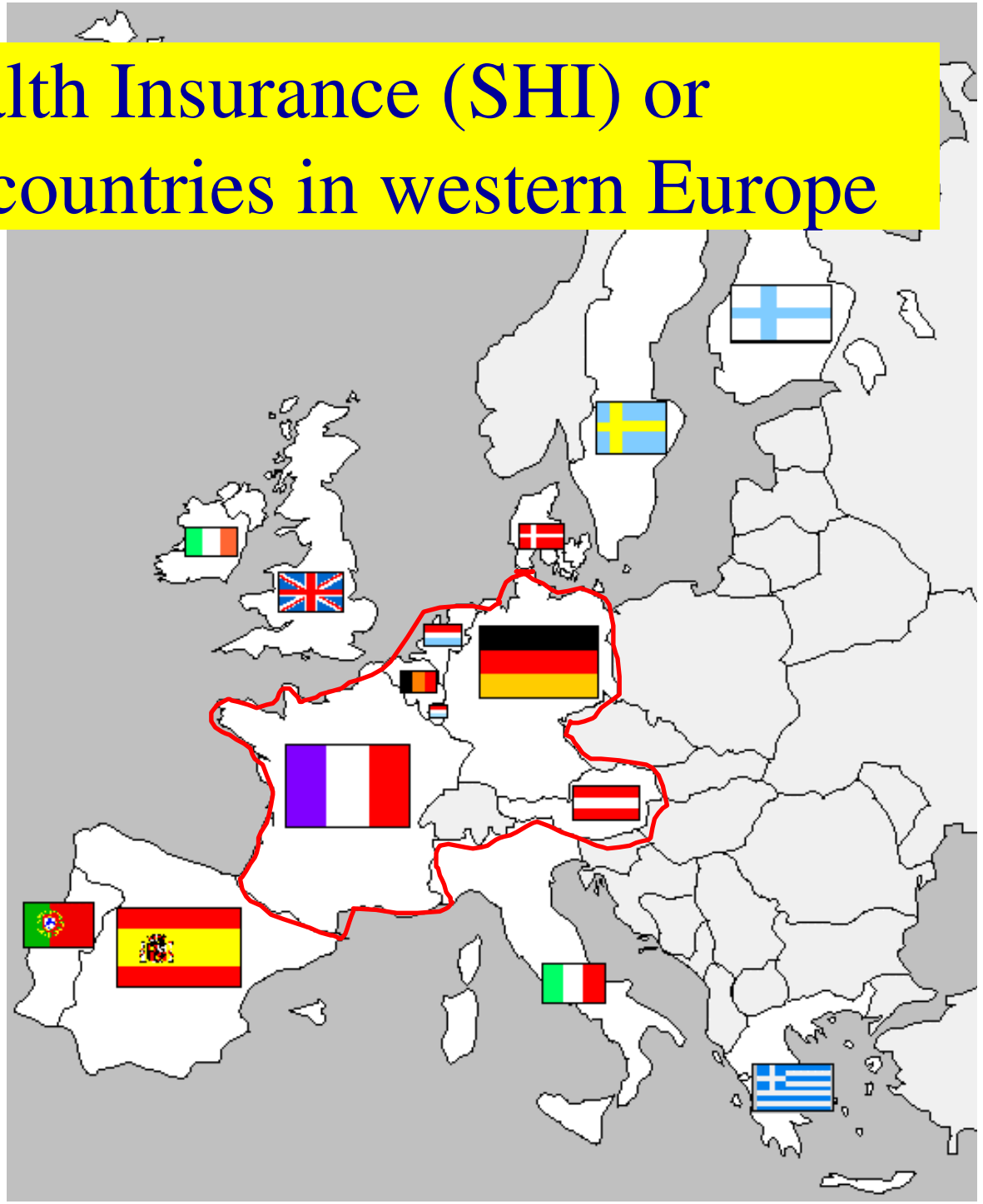
Social Health Insurance (SHI) or „Bismarckian“ countries in western Europe

Commonalities and variations between countries



What makes a health system a SHI system?

Contribution collector

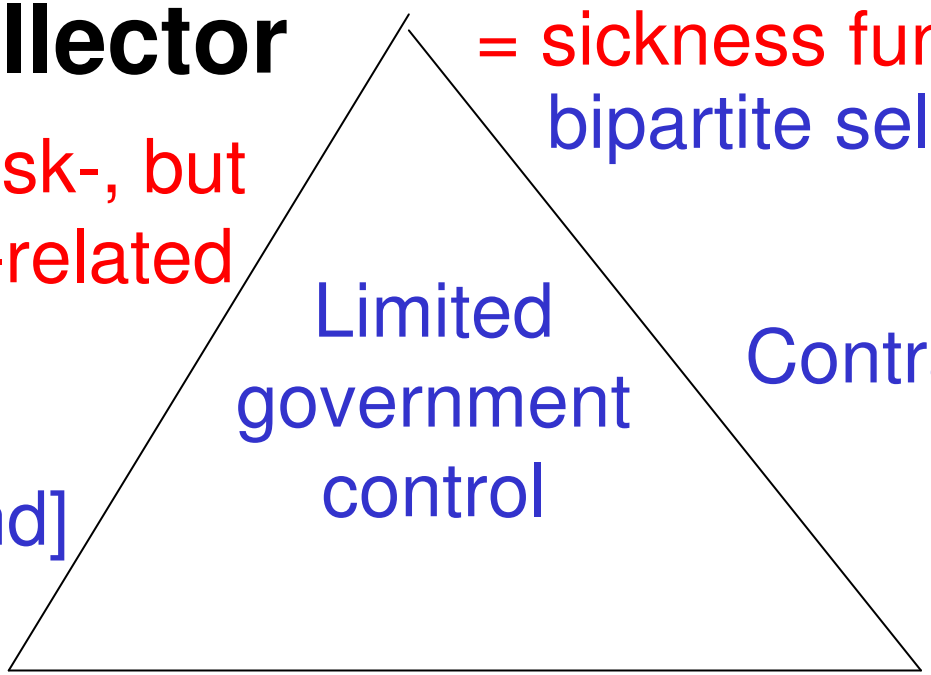
Not (health) risk-, but usually wage-related contribution

[Choice of fund]

Third-party payer

= sickness funds

bipartite self-government



Population

Mandatory insurance

Providers

Public-private mix

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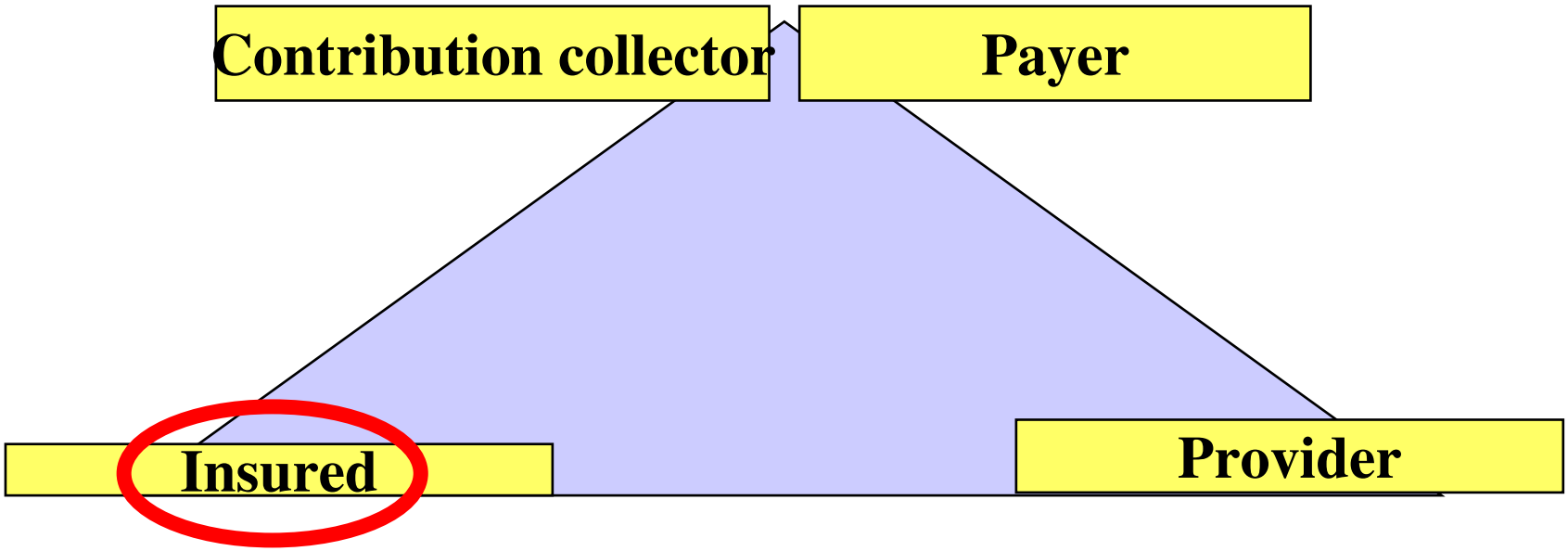
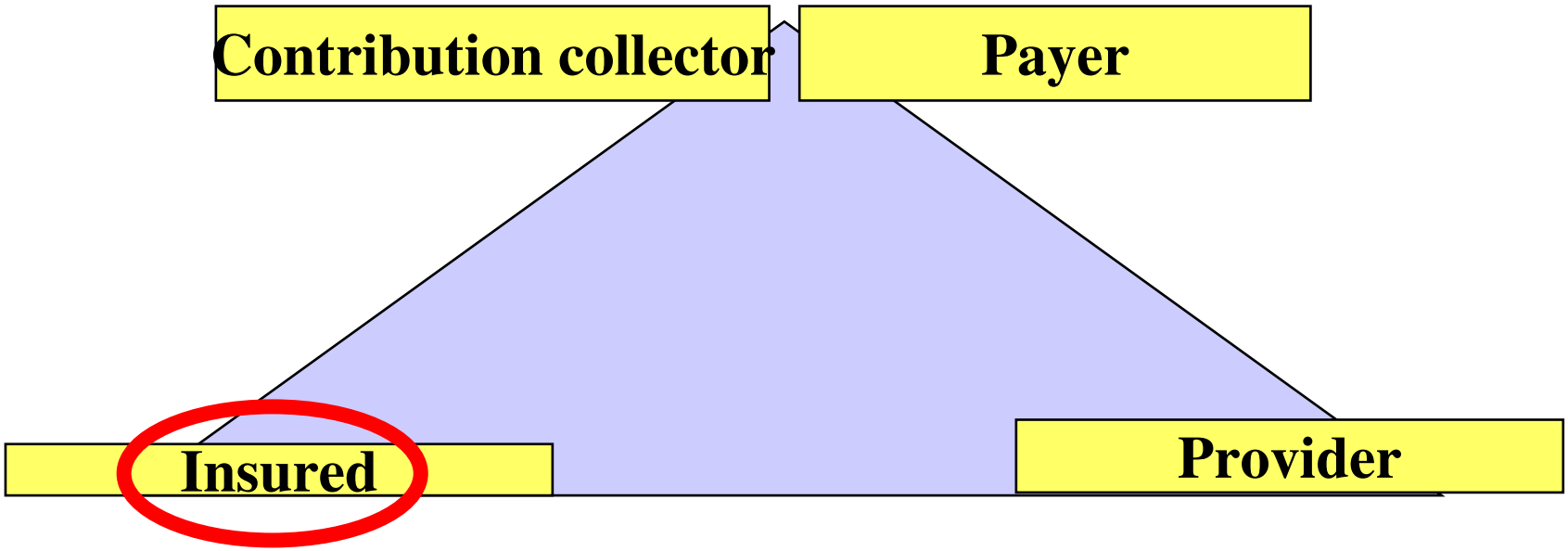
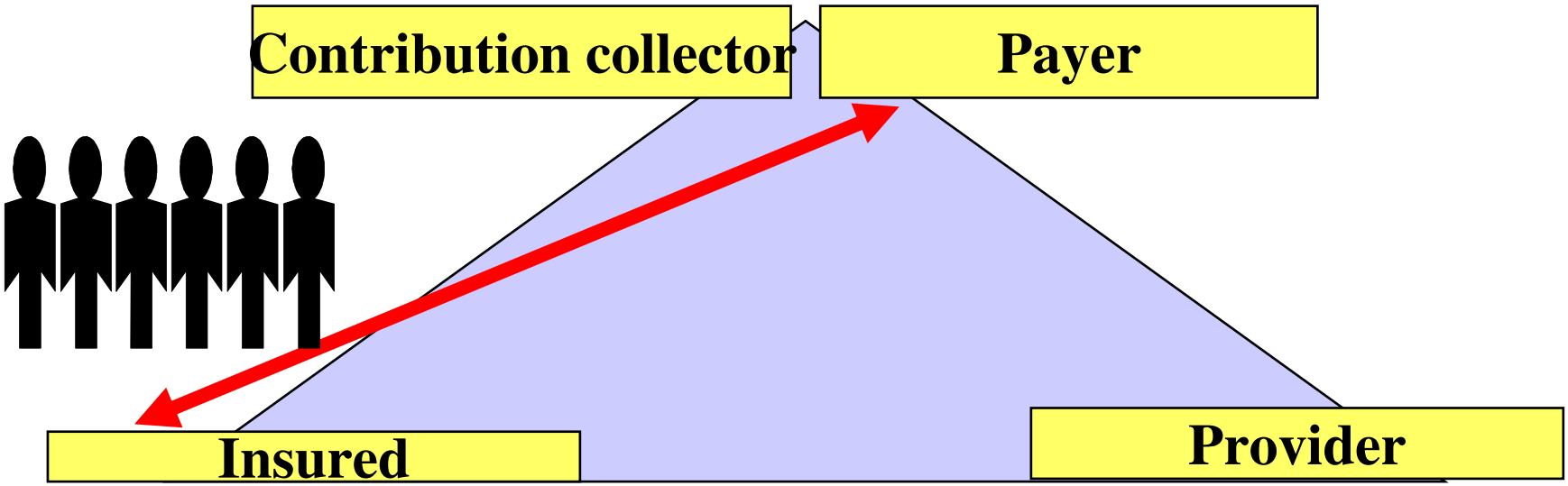


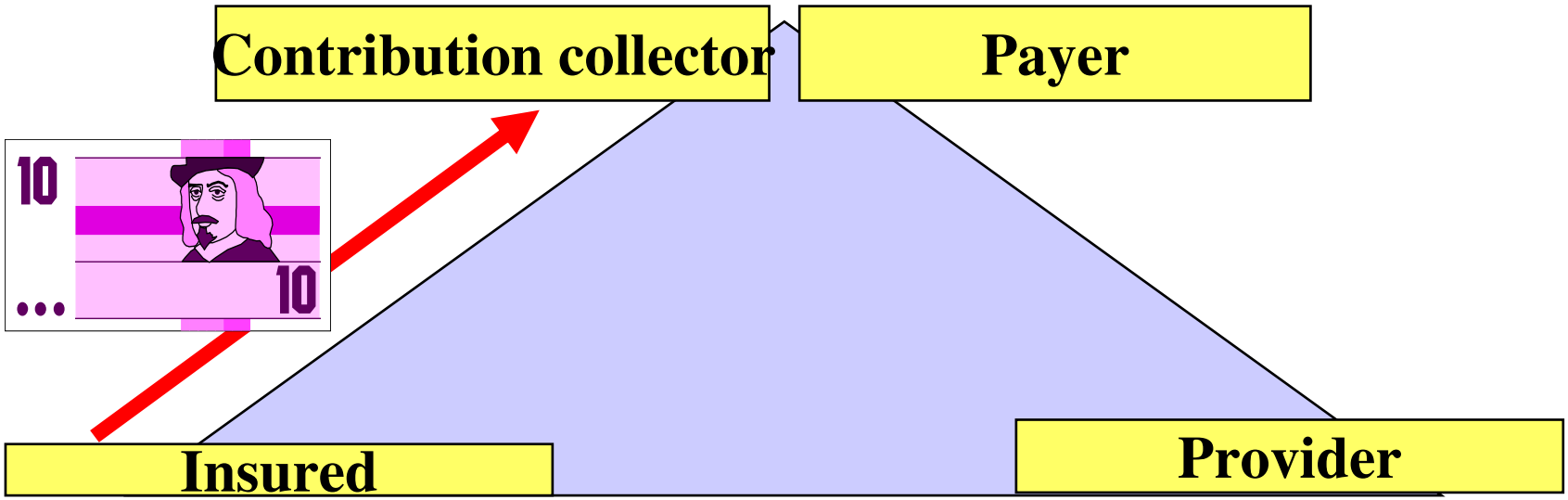
- SHI tradionally tied to employment, later extended to defined other groups (dependents, pensioners, unemployed, students, self-employed etc.)
- 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
- 65% coverage in Netherlands (no choice!)



- Notion of “universal“ coverage very recent phenomenon: legally only for “exceptional expenses“ in the Netherlands (1968), in Switzerland (1996), Belgium (1998) and France (2000) – planned for “ordinary“ health insurance in the Netherlands from 2006

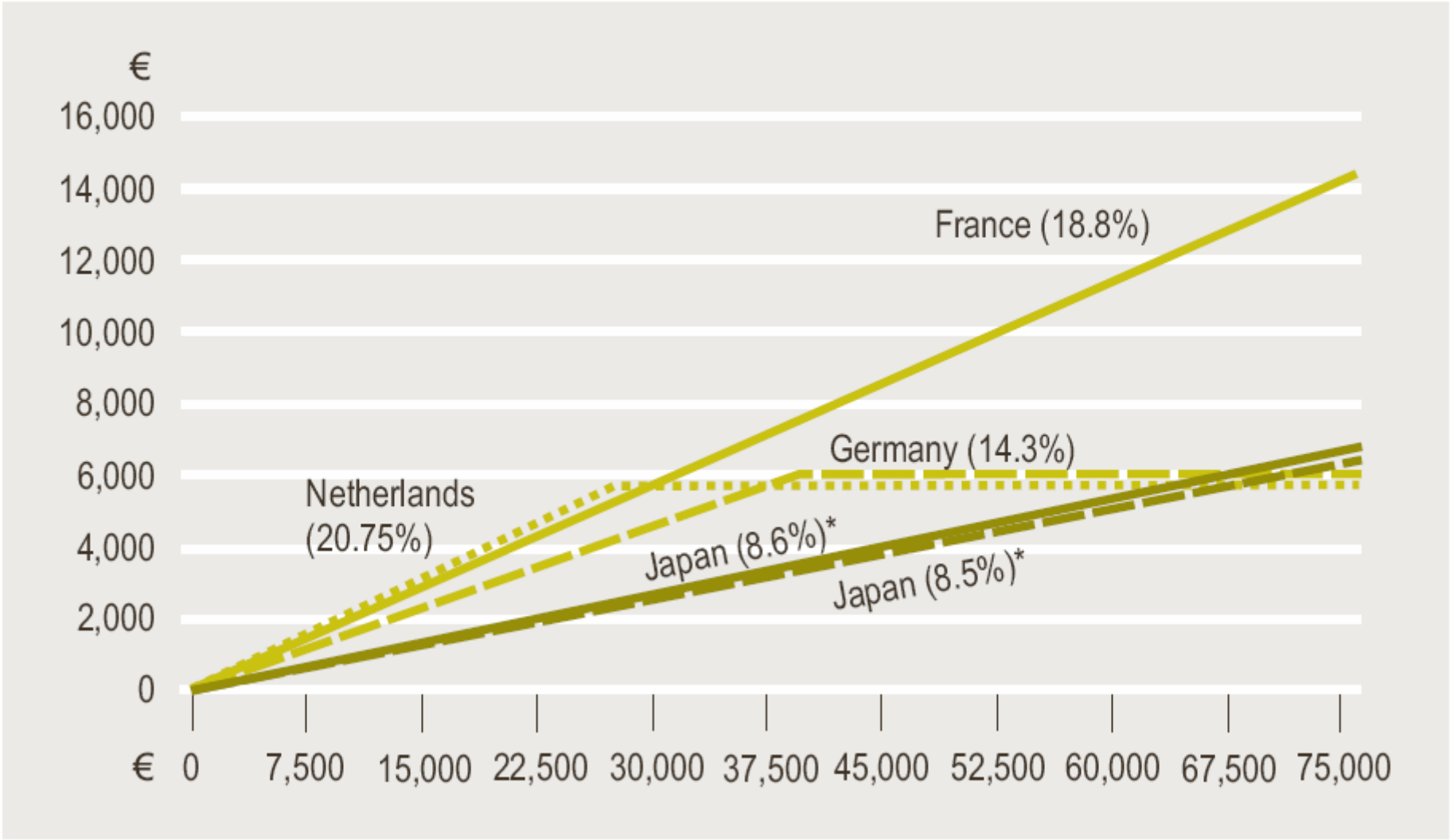


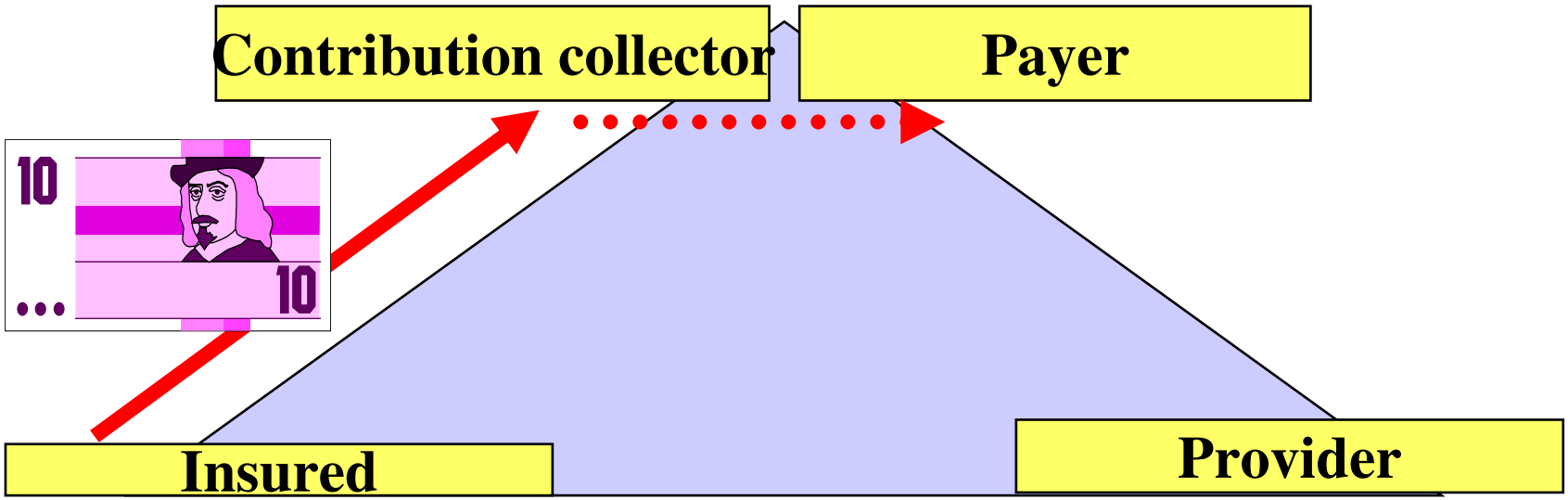
- *pre-determined* membership in Austria, France and Luxembourg
- *free choice* of fund in Belgium, Netherlands (1993-), Germany (1996-) and Switzerland - *the young, well-educated and healthier are changing funds more often, i.e. risk-structure de-mixes!*



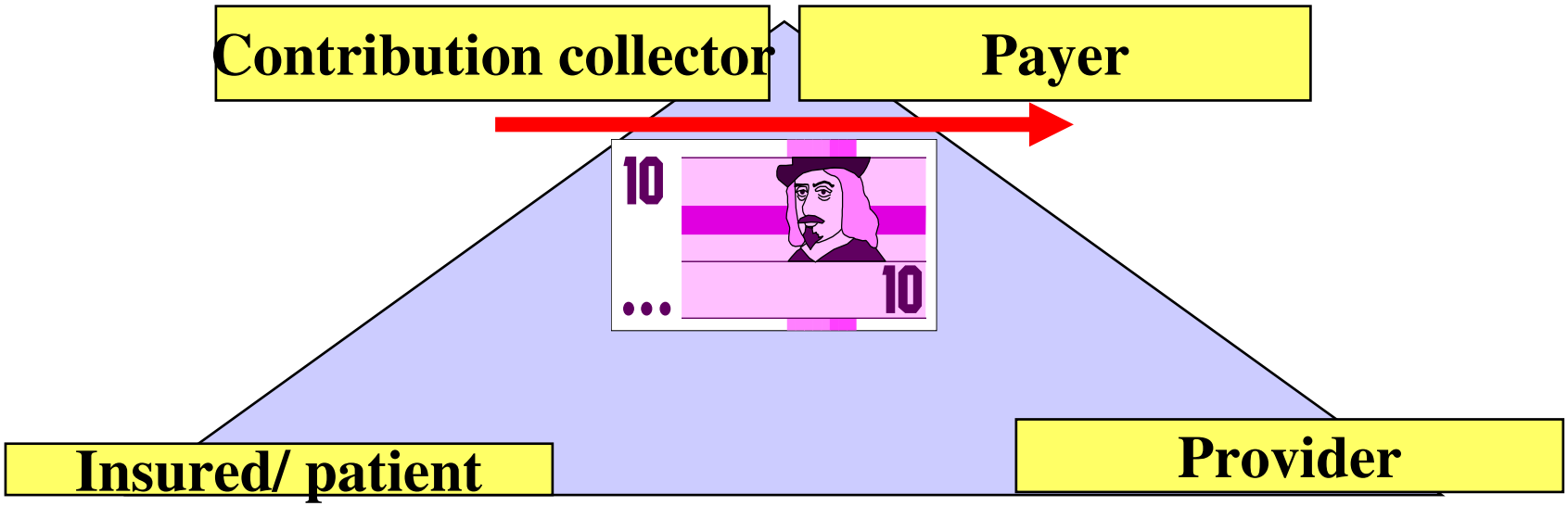
- Traditionally based on wages only (with an upper limit)
- Problem 1: increasing burden on labour costs as other income is rising faster - Solution: broaden income base, e.g. by abolishing upper limit (Belgium, France)
- in France change from wage-based contribution of 6.8% to tax of 6.0% on all income of insured + taxing of pharamaceutical advertising ... *i.e. relief for wage-earners*

Figure 4.2 Contributions at different income levels according to contribution rates in the four countries

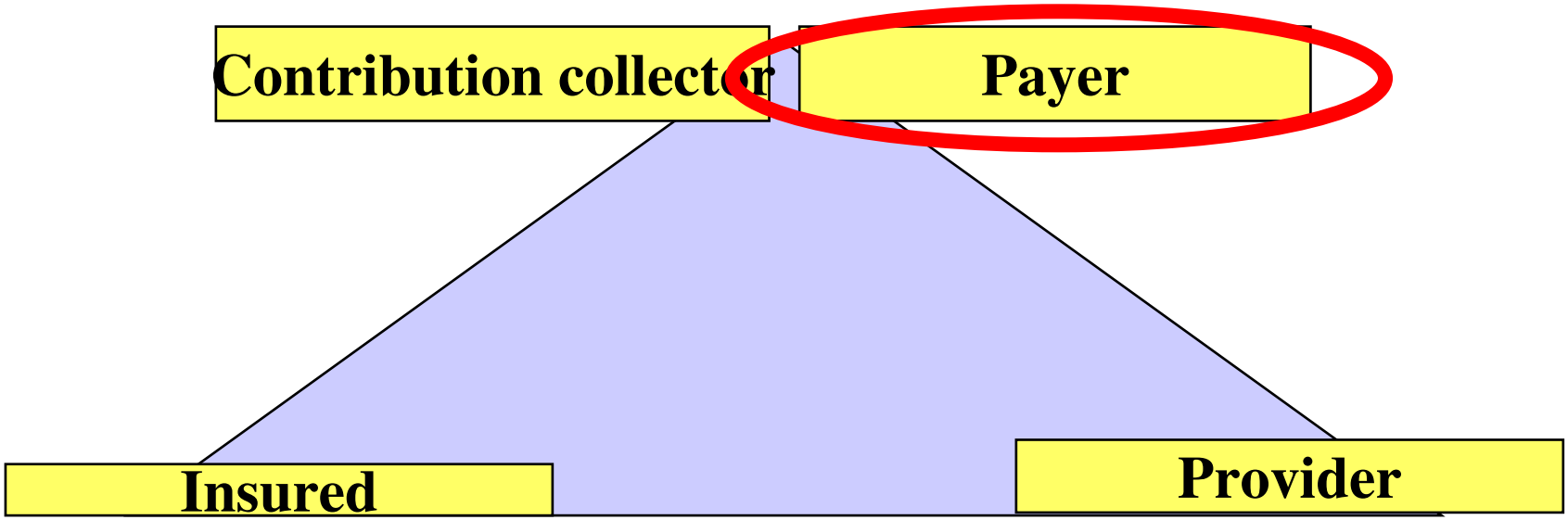




- Problem 2: inequity of contributions as income and risk profiles differ between funds
- Traditional approach: complete pooling of contributions and passing money to funds according to expenditure
- = conflict with efficiency goal and instrument “competition“
- *uniform* contribution rate in A, B, F, L and NL (but differing per-capita premium on top); *differing* rate in Germany; *differing* per-capita premium in Switzerland



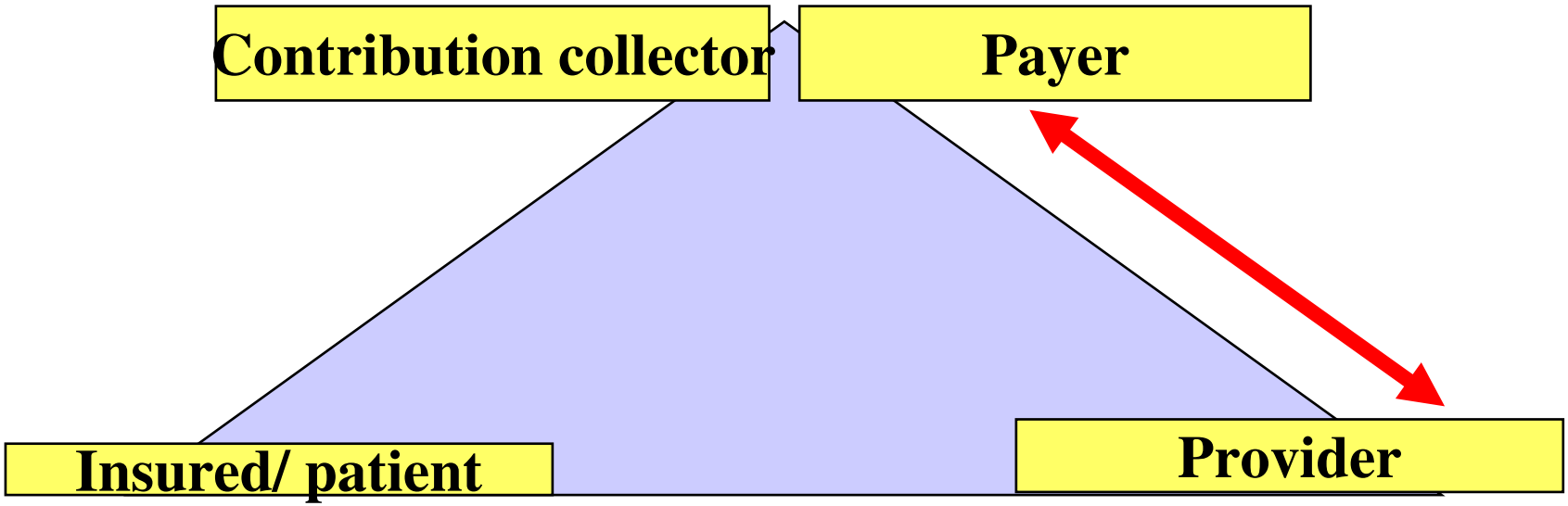
- new approach: prospective allocation of resources (Belgium, Netherlands) or re-allocation (Germany, Switzerland) *– the latter is more difficult as sickness funds view money as "theirs"*
- differences in: area of allocation - nation vs. region (Switzerland), degree of retrospective compensation, factors in the formulas (e.g. region in NL), types of expenditure included, use of high-risk pool



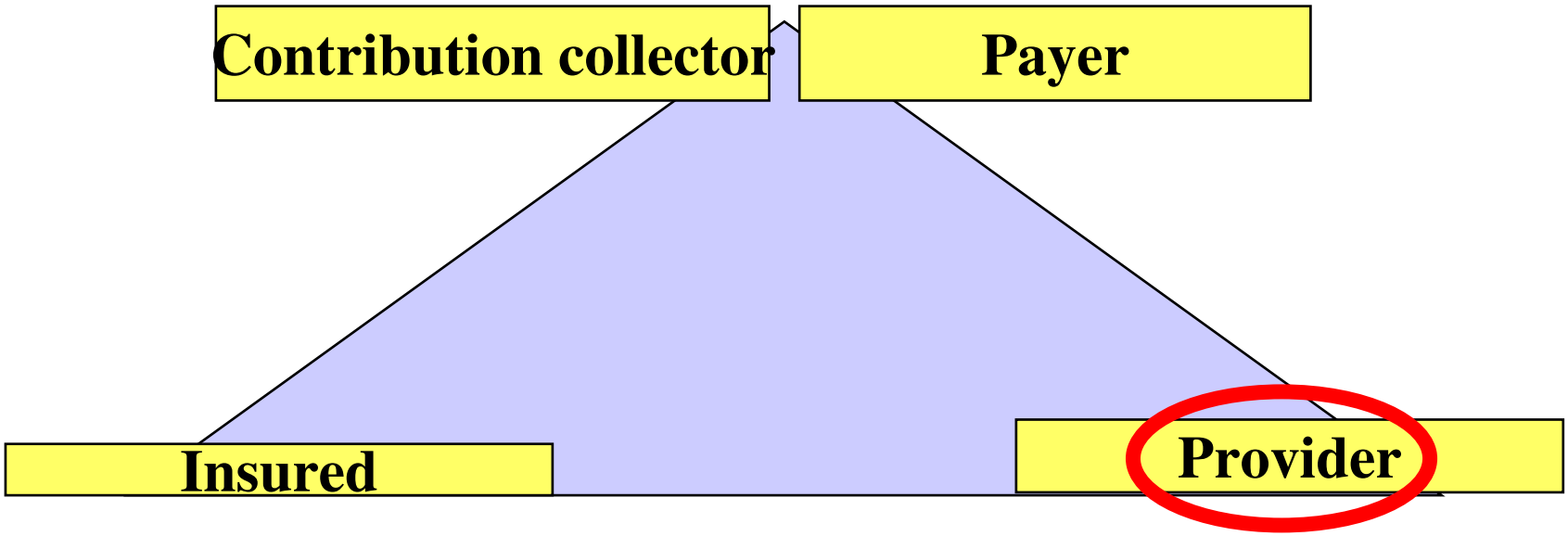
Number of sickness funds

	A*	B*	CH	D*	F*	L*	NL
1992	26	127	191	1223	19	9	27
2002	24	100	93	355	18	9	24

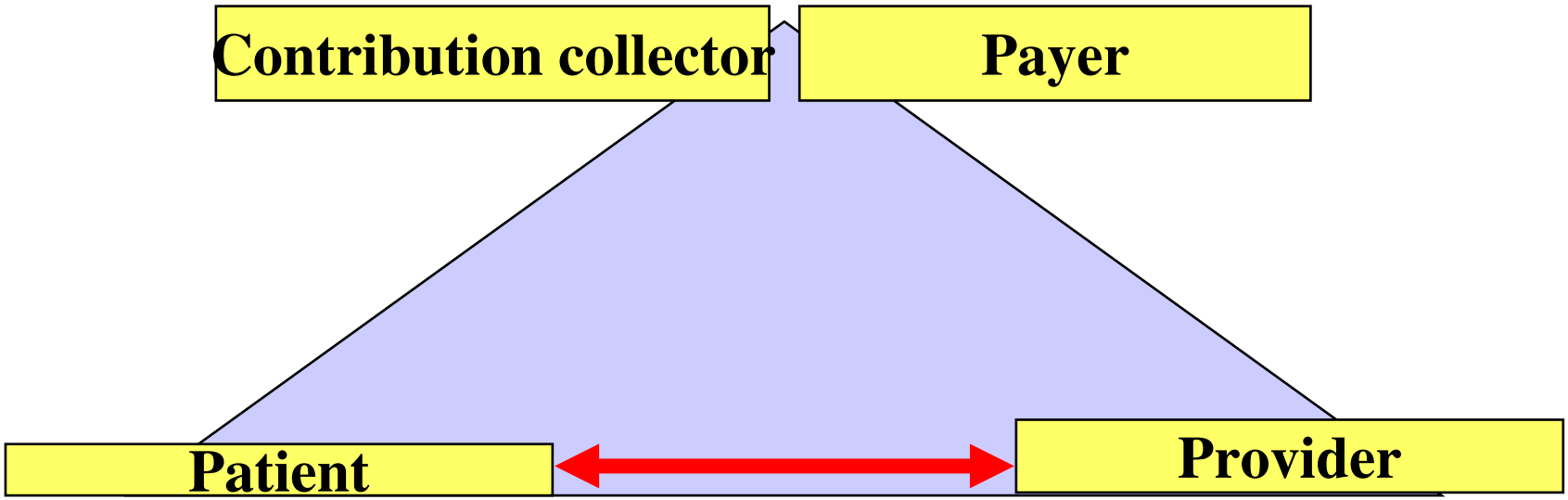
* typical bi-partite government



- all SHI systems are traditionally multi-payer systems – problem: weak cost-control
- solutions: budgets – via state (Austria, France) or collective contracts
  (problem: contradict competition between funds)
- Netherlands: collective contracts are illegal – *but:* funds hardly use selective contracts and reimbursement at lower than maximum rates



	Public	Not-for-profit	For profit
Austria	69%	26%	5%
Belgium	60%	40%	
France	65%	15%	20%
Germany	54%	38%	8%
Luxembourg	50%	50%	
Netherlands	14%	86%	



- Free access = feature of SHI systems (except NL): Gatekeeping = more effective, cheaper, but less popular (also in NL)
- Attempts in the Netherlands to separate “core” benefits from others (to be paid for privately) has failed: dental care was partly re-introduced; not covered services make up only 3% of expenditure

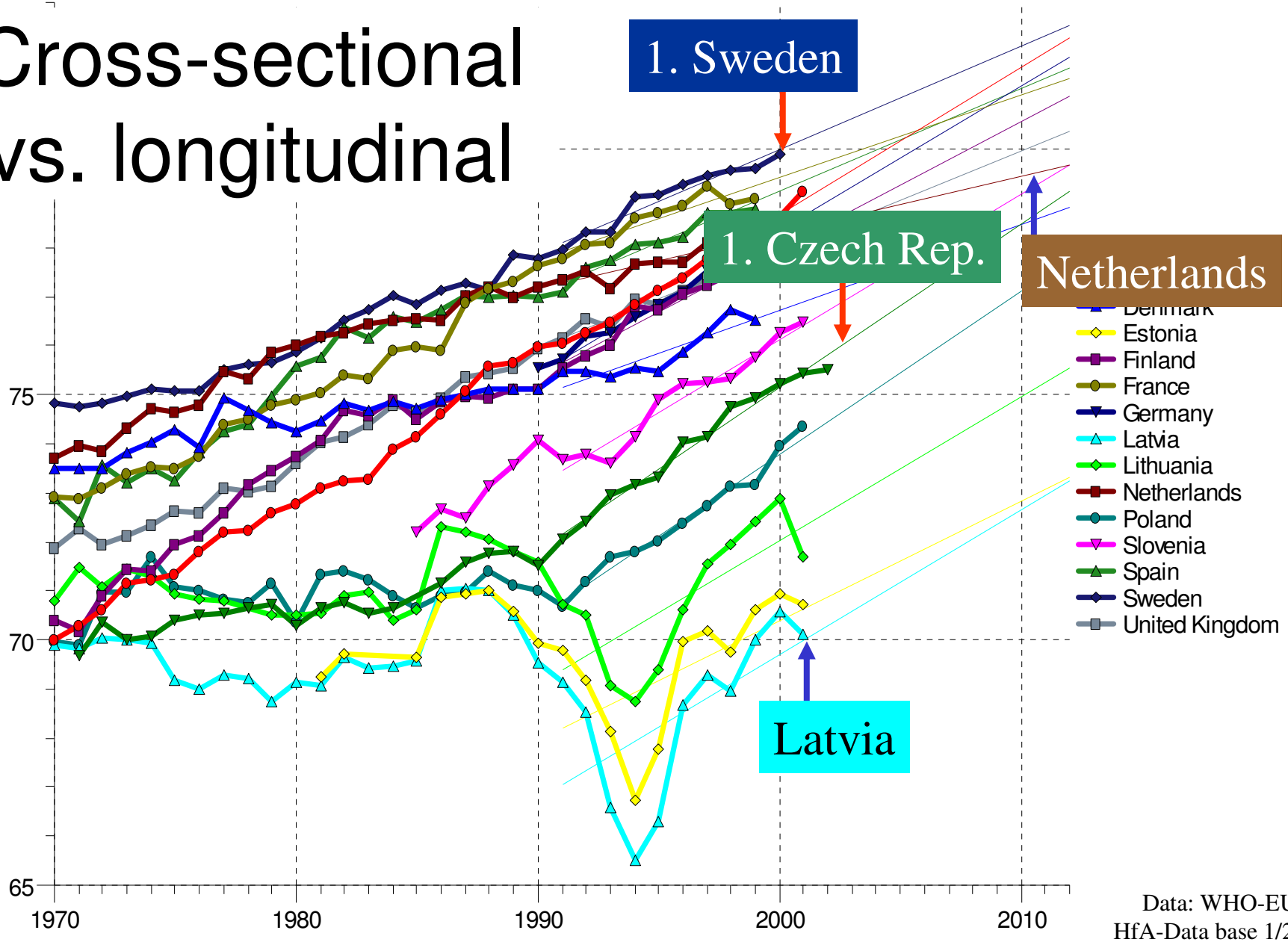
Which system is “best“?

Answer depends on goals, i.e.

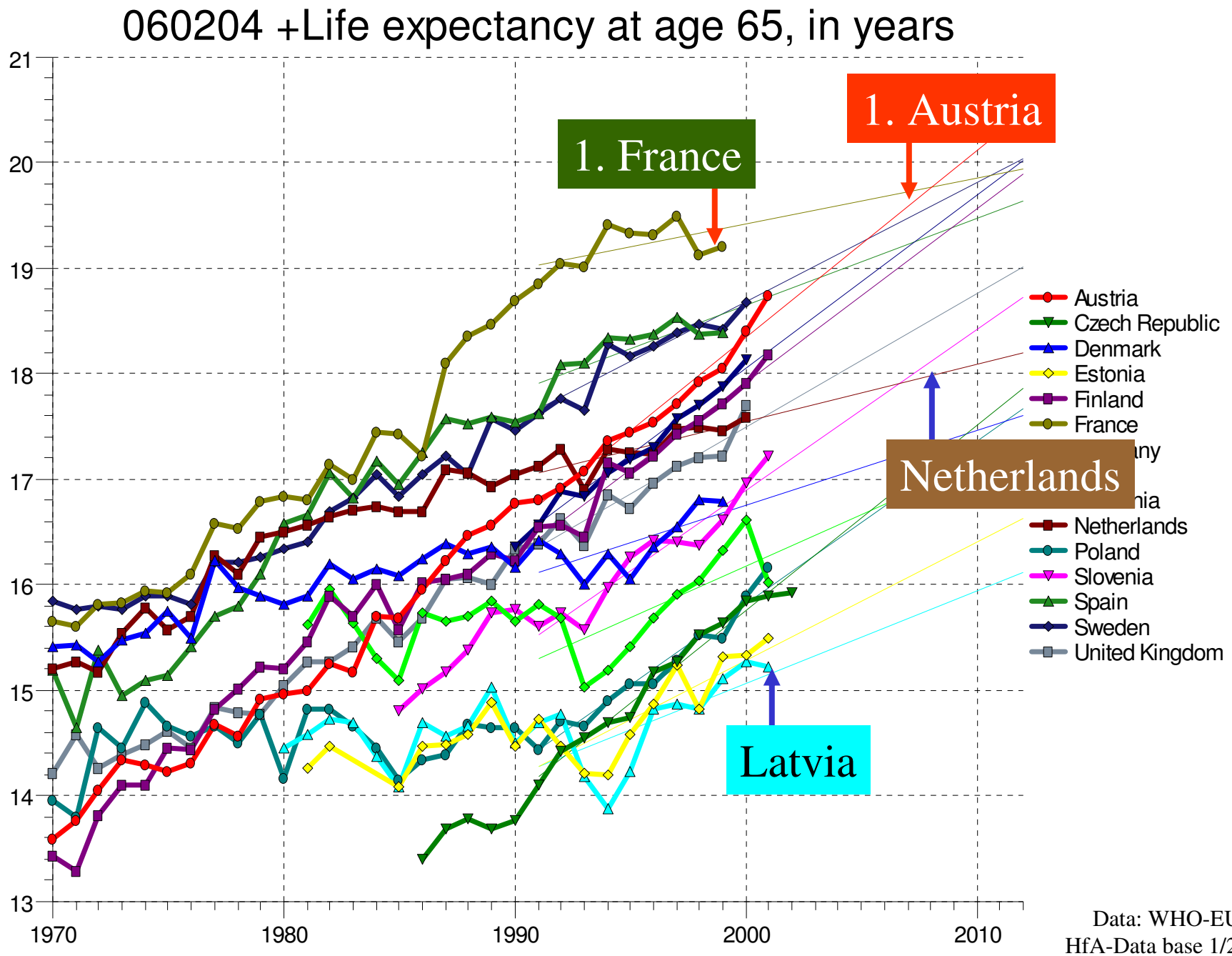
- **Health gain/ improvement**
- **Responsiveness to population needs**
- **Sustainable funding**
- **Equity in health, responsiveness and funding**
- **Efficiency (reaching goals : resources)**

060101 +Life expectancy at birth, in years

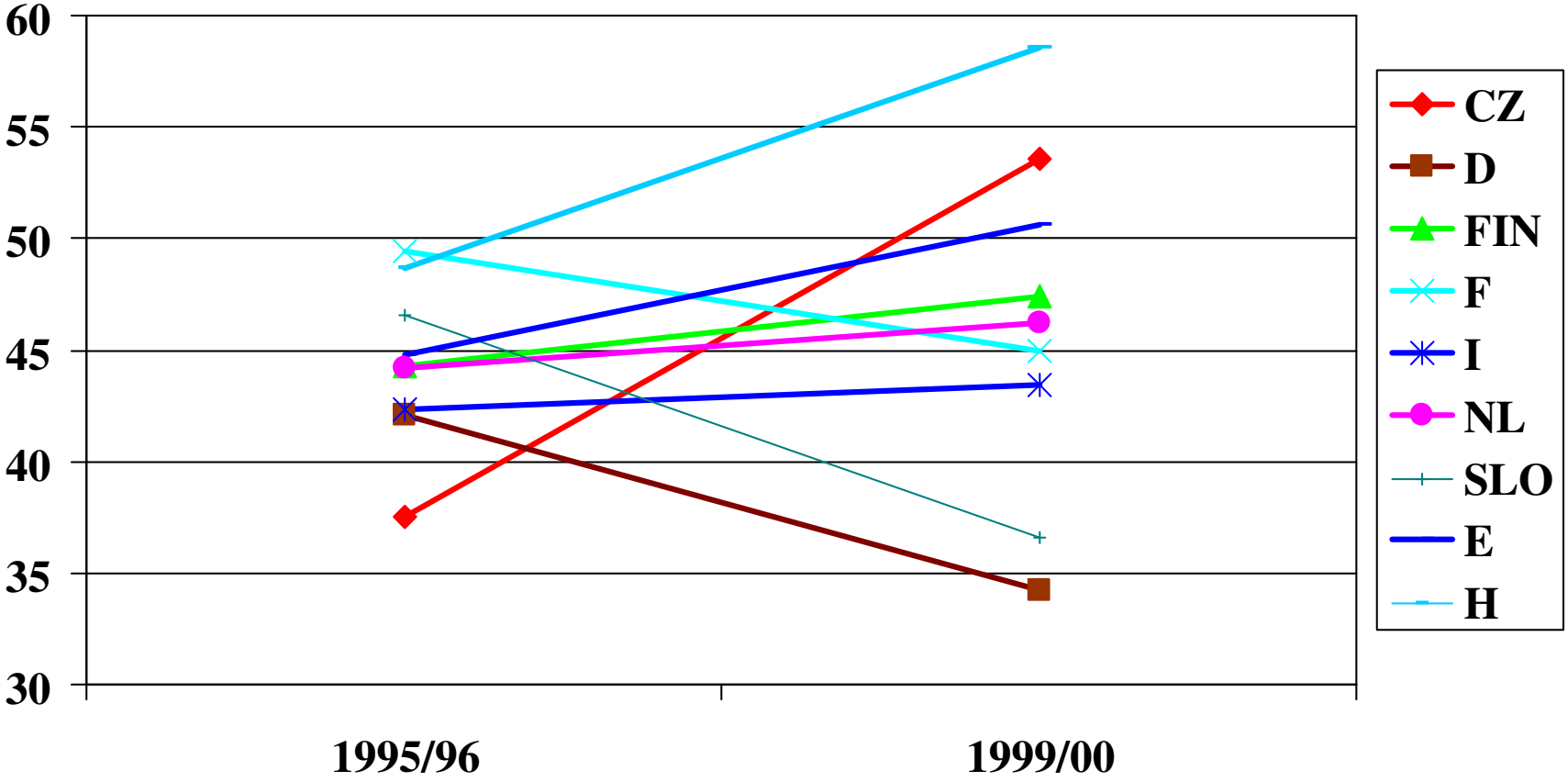
Cross-sectional vs. longitudinal



Data: WHO-EURO
HfA-Data base 1/2004


060204 +Life expectancy at age 65, in years
21
20
19
18
17
16
15
14
13
1970
1980
1990
2000
2010
1. France
1. Austria
Netherlands
Latvia
Austria
Czech Republic
Denmark
Estonia
Finland
France
Netherlands
Poland
Slovenia
Spain
Sweden
United Kingdom
Data: WHO-EURO
HfA-Data base 1/2004

Sufficient blood pressure control 6 months after a CHD hospitalisation



Data: EUROASPIRE „Clinical reality of coronary prevention guidelines“, Lancet 2001; 357: 998

Private financing of health care and financial fairness

	% of private finance of total health care expenditure	
	2002	1990
Greece	47.1	46.3
Switzerland	42.1	47.6
Austria	30.1	26.5
Portugal	29.5	34.5
Belgium	28.8	n.a.
Spain	28.6	21.3
Poland	27.6	8.3
Netherlands	26.7	32.9
Italy	24.4	20.7
Finland	24.3	19.1
France	24.0	23.4
Germany	21.5	23.8
Denmark	16.9	17.3
United Kingdom	16.6	16.4
Norway	14.7	17.2
Sweden	14.7	10.1
Slowakia	10.9	n.a.
Czech Republic	8.6	2.6

Sources: OECD Health Data, first ed. 2004, WHO Health for All Data base 2004, Murray & Evans 2003: pp. 525-6

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